STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE C	ONSTRUCTION	(X3) DATE SURVEY	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING	COMPLETED	
		155196	B. WING		05/06/2013
				ADDRESS, CITY, STATE, ZIP CODE	
NAME OF F	PROVIDER OR SUPPLIE	R		HANNA AVE	
ALTENH	EIM HEALTH & LIV	VING COMMUNITY		NAPOLIS, IN 46237	
(X4) ID	SUMMARY S	STATEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF CORRECTION	(X5)
PREFIX	` `	NCY MUST BE PRECEDED BY FULL	PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	
TAG	REGULATORY O	R LSC IDENTIFYING INFORMATION)	TAG	DEFICIENCY)	DATE
F000000					
F000000	State Licensul Survey dates: 3, and 6, 2013 Facility Number Provider Number: Survey team: Dinah Jones, Patti Allen, SV Marcy Smith, 2, and 3, 2013 Leia Alley, RN and 6, 2013) Census bed ty SN/NF: 65 Residential: 6 Total: 131 Census payor Medicare: 9 Medicaid: 41 Private: 81 Total: 131 Residential sa	April 29, 30, May 1, 2, 3. er: 000103 ber: 155196 100290000 RN-TC V RN (April 29, 30, May 1, 3) I (April 30, May 1, 2, 3, 7pe:	F000000	This plan of correction is to se as Altenheim Health &n Living Community's credible allegation of compliance. Submission of this plan of correction does not constitute an admission by Altenheim Health & Living Community or its management company that the allegations contained in the survey report a true and accurate portrayal the provision of nursing service in this facility. Nor does this submission constitute an agreement or admission of the survey allegations. The facilit requesting a desk review for paper compliance related to the tags cited in this 2567. Additionally, the facility is requesting a paper review IDF F 282 and F329 for omission of citations.	on f f ot are of ees e y is
		ncies reflect state in accordance with 410			

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

(X6) DATE

Any defiency statement ending with an asterisk (*) denotes a deficency which the institution may be excused from correcting providing it is determined that other safegaurds provide sufficient protection to the patients. (see instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID:

ZRO611

Facility ID: 000103

TITLE

DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 06/10/2013 FORM APPROVED OMB NO. 0938-0391

	PLAN OF CORRECTION IDENTIFICATION NUMBER: 155196 A. BUILDING B. WING			COMPLETED 05/06/2013			
	ROVIDER OR SUPPLIER		STREET ADDRESS, CITY, STATE, ZIP CODE 3525 E HANNA AVE INDIANAPOLIS, IN 46237				
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	(X5) COMPLETION DATE		
	IAC 16.2. Quality Review co	ompleted on May 10,					
	2013; by Kimberly						

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID: ZRO611

Facility ID: 000103

If continuation sheet Page 2 of 13

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE CONSTRUCTION (X3) DATE			(X3) DATE S	SURVEY	
AND PLAN (OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING 00 COMPLETED			ETED	
		155196	A. BUII B. WIN			05/06/	2013
			B. WIN		ADDRESS, CITY, STATE, ZIP CODE		
NAME OF P	ROVIDER OR SUPPLIER						
AI TENILI	EIM HEALTH & LIV	ING COMMUNITY			HANNA AVE APOLIS, IN 46237		
					Ai OLio, iiv 40237		
(X4) ID		TATEMENT OF DEFICIENCIES	ID		PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	*	CY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATION OF THE APPROPRIATION	TE	COMPLETION
TAG		LSC IDENTIFYING INFORMATION)	-	TAG	DEFICIENCY)		DATE
F000241 SS=D	483.15(a) DIGNITY AND REINDIVIDUALITY						
	The facility must promote care for residents in a manner and in an environment that maintains or enhances each resident's dignity and respect in full recognition of his						
	or her individualit	y.	EOO	0241	1. Residents # 30 and # 149		06/05/2013
	Paged on aboa	ryotion and intonvious	F00	0241	were not harmed and resumed	1	00/03/2013
		rvation and interview,			eating his/her meals. 2. All	•	
	•	d to maintain the			residents have the potential to	be	
	0 ,	idents by interrupting a			affected. The staff member		
	•	e medications and to			passing medication and the		
	complete an interview with a resident.				speech therapist were		
	(Resident #30,	and #149)			immediately re-educated regarding disruption of residen	ite	
					during meal times. 3. An	11.0	
	Findings Includ	le:			inservice was conducted with	to	
	During an obse	ervation of medication			facility staff, including therapy, ensure awareness to not disru		
	•	at 8:45 a.m., and in			residents during meal times.		
	•	f RN #1, Resident #30			Staff, again including therapist		
	•	d during his breakfast			will be educated upon hire of the		
	•	edications. Resident			same. The DON or her design will monitor three meals per we		
		on included, but was			for one month, then weekly for		
		2 liquid medications he			four weeks, then monthly for tw		
		and pills crushed up			months to ensure residents are		
					not being interrupted during		
		rith applesauce. When			meals. 4. Findings of these		
	• •	ched Resident #30 he			observations will be reviewed during the facility's quarterly		
		u have that nasty			quality assurance performance	<u>.</u>	
	sh**"."				improvement meetings and the		
	. .				plan of action adjusted		
	•	ervation of medication			accordingly.		
	•	at 8:45 a.m., Speech					
	Therapist #1 interrupted Resident #149's breakfast meal and asked, "Is						
	it ok if I ask you	u some questions while					

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID: ZRO611

Facility ID: 000103

If continuation sheet Page 3 of 13

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIF	LE CO	NSTRUCTION	(X3) DATE		
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING COMPLETED				
		155196	B. WING			05/06/	/2013
NAME OF I	PROVIDER OR SUPPLIE	ER.			ADDRESS, CITY, STATE, ZIP CODE		
A. TENII.		VINIO COMMUNITY			HANNA AVE		
ALIENH	EIM HEALTH & LI	VING COMMUNITY	IN	JIAN	APOLIS, IN 46237		
(X4) ID	SUMMARY STATEMENT OF DEFICIENCIES		ID		PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX TAG	`	NCY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)	PREF TA		(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	TE	COMPLETION DATE
IAG		your breakfast?"	IA.	J			DATE
	1 -	pist #1 asked Resident					
	1 -	I questions, like family					
		none numbers and					
	•	itions were you taking at					
		e were 7 other residents					
		oom along with					
	_	9. Resident #149					
		g her meal while she					
		th Speech Therapist #1.					
	Continued observation on 5/2/12 at						
		eech Therapist #1 and					
		9 was then interrupted					
		o asked if she could					
		ons. The conversation					
	went as follow						
	LPN#1, "I hat	te to interrupt you but I					
	need to give y	ou some medicines."					
	Speech Thera	pist #1, "You're not					
	interrupting he	er any more than I am					
	(and giggles),	but she said it was ok					
	that I talked to	her during breakfast."					
	LPN#1, "You	are doing an					
	assessment o	f her" and indicated, "If					
	she said its of	k, its ok."					
	During an interview with Resident						
		3 at 11:10 a.m., she					
		was not upset or					
		eing interrupted during					
	her meal.						
	During an inte	rview with the B wing					1

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Event ID: ZRO611

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DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 06/10/2013 FORM APPROVED OMB NO. 0938-0391

AND PLAN OF CORRECTION IDENTIFICATION NUMBER: 155196		A. BUILDING B. WING	00	COMPLETED 05/06/2013	
	PROVIDER OR SUPPLIER EIM HEALTH & LIVING COMMUNITY	STREET ADDRESS, CITY, STATE, ZIP CODE 3525 E HANNA AVE INDIANAPOLIS, IN 46237			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIAT DEFICIENCY)	(X5) COMPLETION DATE	
TAG	Unit Manager and the Director of Nursing (DON) on 5/1/13 at 9:00 a.m., they indicated they do not have an exact procedure for providing medications during meals. During an interview with the Director of Nursing on 5/2/13 at 2:30 p.m. she indicated they do not have a policy in regards to dignity of the residents. 3.1-3(t)	TAG	DEFICIENCY)	DATE	

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID: ZRO611

Facility ID: 000103

If continuation sheet Page 5 of 13

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE CONSTRUCTION (X3) DATE SURVE			SURVEY		
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING COMPLET			ETED	
		155196	B. WIN			05/06/	2013
			B. WIIN		ADDRESS, CITY, STATE, ZIP CODE		
NAME OF P	ROVIDER OR SUPPLIER						
A1 TENUI					HANNA AVE IAPOLIS, IN 46237		
ALIENTI	EIM HEALTH & LIV	ING COMMONT Y		INDIAN	IAPOLIS, IN 46237		
(X4) ID	SUMMARY S	TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	(EACH DEFICIEN	CY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	ΓE	COMPLETION
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION)		TAG	DEFICIENCY)		DATE
F000282	483.20(k)(3)(ii)						
SS=D	SERVICES BY Q	UALIFIED PERSONS/PER					
	CARE PLAN						
		vided or arranged by the					
	•	ovided by qualified					
	•	lance with each resident's					
	written plan of car	re.					0.5/0.7/0.10
			F00	0282	Resident #69 was not harm	ned	06/05/2013
	Based on recor	rd review and			and has routinely taken these		
	interview, the fa	acility failed to ensure			medications for years without		
	a resident rece	iving blood pressure			negative effects, frequent		
		as monitored according			hospitalizations, etc. Vital sigr were obtained and all well with		
	to the plan of c	_			normal limits. The physician	III I	
	•	met the criteria for			expressed no concerns due to		
					the stability of the resident's		
		cation monitoring in a			condition on his medication		
	total sample of	21. (Resident #69)			regimen, the length of time he		
					has been managed successful	lly	
	Findings includ	e:			on these medications and the		
	_				frquency which the physician		
	The clinical rec	ord of Resident #69			sees this resident. The facility		
		on 5/2/13 at 8:51 a.m.			respectfully requests IDR.2.		
	was reviewed t	on 6/2/10 at 6.51 a.m.			Residents taking multiple		
	D: ()	D : 1 1 1/100 : 1 1 1			medications for hypertension	-1	
	•	Resident #69 included,			management have the potential to be affected. Medcial record		
		nited to, high blood			were reviewed to ensure blood		
	pressure, strok	e, and congestive			pressures were obtained and	4	
	heart failure.				recorded in the medical record	l.	
					No physician notification was		
	A careplan for l	Resident #69, dated			indicated based upon values		
	•	odated through 6/4/13,			obtained.3. The DON or her		
	•	_			designee will audit 30 resident	s	
		as at risk for having			monthly for three months to		
		due to his history of a			ensure vital signs are obtained		
	stroke and hav				per the plan of care then quart	erly	
	pressure. The	goal was he would			until 100% compliance is		
	have no sympto	oms of a stroke or high			achieved.4. The findings of th		
		crisis. Approaches			audits will be reviewed during	tne	
	•	itor [blood pressure]			facility's quarterly quality		
	miciaaca, MOH	iroi [niood hiessaie]	1		assurance performane		

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Event ID: ZRO611

Facility ID: 000103

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DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 06/10/2013 FORM APPROVED OMB NO. 0938-0391

AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MULTIPLE CO	ONSTRUCTION 00	(X3) DATE SURVEY COMPLETED
	155196	A. BUILDING B. WING		05/06/2013
NAME OF F	PROVIDER OR SUPPLIER		ADDRESS, CITY, STATE, ZIP CODE	l
		3525 E		
	EIM HEALTH & LIVING COMMUNITY		IAPOLIS, IN 46237	
(X4) ID PREFIX	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL	ID PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE	(X5) COMPLETION
TAG	REGULATORY OR LSC IDENTIFYING INFORMATION)	TAG	CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	DATE DATE
	and condition. Notify physician of		improvement meetings and the	ne
	persistent elevations."		plan of action adjusted accordingly.	
	Recapitulated physician's orders for			
	May, 2013, with an original date of			
	3/5/10, indicated Resident #69 was to			
	receive hydrochlorothiazide 25 mg			
	(milligrams) once per day, lisinopril 40			
	mg once per day, and atenolol 100 mg once per day. Lisinopril and			
	atenolol are medications used to treat			
	high blood pressure.			
	Hydrochlorothiazide is used to treat			
	congestive heart failure, and a side			
	effect of this medication can be low			
	blood pressure.			
	Review of Medication Administration			
	Records for Resident #69, for			
	October, November, and December,			
	2012, and January, February, March,			
	and April, 2013, indicated he received hydrochlorothiazide, lisinopril, and			
	atenolol everyday as ordered.			
	attitude of organization of the organization o			
	Review of vital signs taken for			
	Resident #69 indicated his blood			
	pressure was taken on the following			
	dates:			
	October 2012: none			
	November 2012: none			
	December:			

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID: ZRO611

Facility ID: 000103

If continuation sheet

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) M	ULTIPLE CO	NSTRUCTION	(X3) DATE S		
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER: 155196	A. BUI	LDING	00	COMPL: 05/06/	
		133190	B. WIN		PPPPGG GYPY GT GP GOP	03/00/	2013
NAME OF P	PROVIDER OR SUPPLIER				ADDRESS, CITY, STATE, ZIP CODE HANNA AVE		
ALTENHI	EIM HEALTH & LIV	ING COMMUNITY			APOLIS, IN 46237		
(X4) ID		TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX TAG	`	CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)		PREFIX TAG	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA' DEFICIENCY)	ΓE	COMPLETION DATE
1710		pressure = 128/76		mo	·		DATE
		pressure = 130/79					
		d pressure = 126/71					
		'					
	January:						
		pressure = 120/52					
	1/17/13 blood រ	oressure = 112/56					
	February:						
		ressure = 143/86					
	2/0/10 blood pressure = 140/00						
	March 2013: none						
	April 2013: no	ne					
	of Nursing (DO were any other on Resident #6 receiving 3 me which would af	1:00 a.m., the Director (N) was asked if there (blood pressures taken (S), since he was dications everyday, fect his blood pressure (planned to monitor his (s).					
	provided 2 phy	40 p.m., the DON sician progress notes 9 which indicated:					
		pressure = 157/76 pressure = 157/76.					
	had checked R	at that time the facility resident #69's blood 3/13 and it was 105/66.					

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Event ID: ZRO611

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DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 06/10/2013 FORM APPROVED OMB NO. 0938-0391

	OF CORRECTION IDENTIFICATION NUMBER: 155196	A. BUILDING B. WING	00 	COMPLETED 05/06/2013			
	PROVIDER OR SUPPLIER EIM HEALTH & LIVING COMMUNITY	STREET ADDRESS, CITY, STATE, ZIP CODE 3525 E HANNA AVE INDIANAPOLIS, IN 46237					
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA' DEFICIENCY)	(X5) COMPLETION DATE			
	The DON indicated at that time she had added these 2 physician documented blood pressures and the one taken on 5/3/13 to Resident #69's vital sign record on 5/3/13. She indicated the facility should have taken the resident's blood pressure more often between October, 2012 and April, 2013, as written in the resident's care plan. 3.1-35(g)(2)						

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID: ZRO611

Facility ID: 000103

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STATEMEN	STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE CONSTRUCTION			(X3) DATE SURVEY	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	a. Building 00			COMPLETED	
		155196	B. WIN			05/06/	2013
			1		ADDRESS, CITY, STATE, ZIP CODE		
NAME OF P	PROVIDER OR SUPPLIER			3525 E	HANNA AVE		
ALTENHI	EIM HEALTH & LIV	ING COMMUNITY			APOLIS, IN 46237		
(X4) ID	SUMMARY S	TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	`	CY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIAT	ΓE	COMPLETION
TAG		LSC IDENTIFYING INFORMATION)		TAG	DEFICIENCY)		DATE
F000329 SS=D	from unnecessary drug is any drug of dose (including dose (including dose (including dose (including)) are considered in the consequences where should be reduce combinations of the sased on a comparesident, the faciliar residents who have drugs are not given antipsychotic drug treat a specific condocumented in the residents who use receive gradual dose including the same consequences.	DRUGS rug regimen must be free y drugs. An unnecessary when used in excessive uplicate therapy); or for n; or without adequate hout adequate indications ne presence of adverse nich indicate the dose d or discontinued; or any he reasons above. Therefore the discontinued and the continued and the series of the	FOO	0329	1. Resident #69 was not harm		06/05/2013
	interview, the fa a resident rece medications wa adverse reaction who met the cri medication more sample of 21. Findings include	acility failed to ensure iving blood pressure as monitored for on for 1 of 10 residents iteria for review of nitoring in a total (Resident #69)	F00	0329	and has routinely taken these medications for years without negative effects, frequent hospitalizations, etc. Vital signs werew obtained and all well winormal limits. The physician expressed no concerns due to the stability of the resident's condition on his medication regimen, the length of time he has been managed successful on these medications and the frquency which the physician sees this resident. The facility respectfully requests IDR.2.	s thin	06/05/2013

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Event ID: ZRO611

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If continuation sheet Page 10 of 13

STATEMEN	STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) M	ULTIPLE CO	ONSTRUCTION	(X3) DATE SURVEY
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A DITE	LDING	00	COMPLETED
		155196		LDING		05/06/2013
			B. WIN		ADDRESS CITY STATE ZID CODE	
NAME OF P	PROVIDER OR SUPPLIEF	8			ADDRESS, CITY, STATE, ZIP CODE	
A1 TEAU		(NIC COMMUNITY)			HANNA AVE	
ALTENH	EIM HEALTH & LIV	ING COMMUNITY		INDIAN	APOLIS, IN 46237	
(X4) ID	SUMMARY STATEMENT OF DEFICIENCIES			ID	PROVIDER'S PLAN OF CORRECTION	(X5)
PREFIX	(EACH DEFICIEN	ICY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE	COMPLETION
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION)		TAG	DEFICIENCY)	DATE
	Diagnoses for but were not lir pressure, strok failure. A careplan for 7/14/10, and u indicated he wanother stroke stroke and have pressure. The have no sympt blood pressure included, "Monand condition, persistent elevent Recapitulated May, 2013, wit 3/5/10, indicate receive hydroc (milligrams) on mg once per datenolol are me high blood preshydrochlorothic congestive head adverse reactive effect) of this me blood pressure.	Resident #69 included, mited to, high blood ite and congestive heart Resident #69, dated pdated through 6/4/13, as at risk for having due to his history of a ring high blood goal was he would roms of a stroke or high ecrisis. Approaches ation [blood pressure] Notify physician of ations." physician's orders for h an original date of red Resident #69 was to hlorothiazide 25 mg rice per day, lisinopril 40 ay, and atenolol 100 ay. Lisinopril and redications used to treat soure. azide is used to treat redication and an on (undesired side redication can be low extended.)			Residents taking multiple medications for hypertension management have the potentito be affected. Medical records were reviewed to ensure blood pressures were obtained and recorded in the medical record. No physician notification was indicated based upon values obtained.3. The DON or her designee will audit 30 resident monthly for three months to ensure vital signs are obtained per the plan of care then quart until 100% compliance is achieved.4. The findings of the audits will be reviewed during facility's quarterly quality assurance performane improvement meetings and the plan of action adjusted accordingly.	al s d derly ese the
	Records for Re	esident #69, for				

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Event ID: ZRO611

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If continuation sheet

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA			(X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY				
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUII	LDING	00	COMPL	
		155196	B. WIN	G		05/06/	2013
NAME OF P	PROVIDER OR SUPPLIER	3		STREET A	ADDRESS, CITY, STATE, ZIP CODE		
					HANNA AVE		
ALTENHI	EIM HEALTH & LIV	ING COMMUNITY		INDIAN	APOLIS, IN 46237		
(X4) ID	SUMMARY S	TATEMENT OF DEFICIENCIES		ID PROVIDER'S PLAN OF CORRECTION			(X5)
PREFIX	(EACH DEFICIEN	CY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATION OF THE APPROPRIATION	ΓE	COMPLETION
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION)		TAG	DEFICIENCY)		DATE
	October, Nove	mber, and December,					
	2012, and Jani	uary, February, March,					
	and April, 2013	3, indicated he received					
	hydrochlorothia	azide, lisinopril, and					
	atenolol everyo	day, as ordered.					
	Review of vital	signs taken for					
	Resident #69 i	ndicated his blood					
	pressure was t	aken on the following					
	dates:	-					
	October 2012: none						
	November 201	2: none					
	December:						
		pressure = 128/76					
		pressure = 130/79					
		d pressure = 126/71					
	12/1//12 5166	a p. 666a. 6 126/11					
	January:						
	•	pressure = 120/52					
		pressure = 112/56					
	., .,, ., 5,5504	p. 555410 1 12/00					
	February:						
	•	ressure = 143/86					
		1000010 - 170/00					
	 March 2013: r	none					
	WIGHTON 2010.	IOTIO					
	April 2013: no	nο					
	April 2013, 110	IIIC					
	On 5/3/13 at 1	1:00 a.m., the Director					
		N) was asked if there					
	,	•					
		blood pressures taken					
	on Resident#6	69, since he was					

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Event ID: ZRO611

Facility ID: 000103

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	T OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY					
AND PLAN OF CORRECTION		IDENTIFICATION NUMBER:		A. BUILDING 00		COMPLETED		
	155196		B. WING			05/06/2013		
NAME OF P	ROVIDER OR SUPPLIER			STREET A	DDRESS, CITY, STATE, ZIP CODE			
				3525 E HANNA AVE				
ALTENHEIM HEALTH & LIVING COMMUNITY				INDIAN	APOLIS, IN 46237			
(X4) ID	SUMMARY STATEMENT OF DEFICIENCIES			ID	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		(X5)	
PREFIX	(EACH DEFICIENCY MUST BE PRECEDED BY FULL			PREFIX			COMPLETION	
TAG	REGULATORY OR LSC IDENTIFYING INFORMATION)			TAG			DATE	
	receiving 3 medications everyday which would affect his blood pressure							
	and being care planned to monitor his blood pressure.							
	On 5/3/13 at 1:40 p.m., the DON							
	provided 2 physician progress notes							
	for Resident #69 which indicated:							
	10/24/12 blood pressure = 157/76							
	11/20/12 blood pressure = 157/76.							
	She indicated at that time the facility							
	had checked Resident #69's blood							
	pressure on 5/3/13 and it was 105/66.							
	The DON indicated at that time she							
	had added the	se 2 physician						
	documented bl	ood pressures and the						
	one taken on 5	/3/13 to Resident #69's						
	vital sign recor	d on 5/3/13. She						
	indicated the facility should have taken the resident's blood pressure more often between October, 2012 and April, 2013.							
	, , , , , , , , , , , , , , , , , , ,							
	3.1-48(a)(3)							
	- (- /(- /							

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID: ZRO611

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